

# Don't RISK IT

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## Step 2: Cover Yourself



### "Sick" Insurance

Sure, mom and dad's policy covers you now, but soon you're going to have to make some choices. After you head out on your own, who will cover you when you're sick? Most people will find health coverage through their employer. Some people own their own business and are not offered health insurance, or want an individual policy. Here is some information to use when shopping for insurance.

#### If you're headed out on your own...

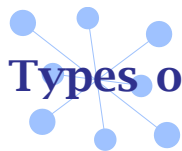
Most family policies will cover a dependent (you) while you're in the house and under the age of 19. Once you are out on your own, the first thing you need to know is whether or not your employer offers health insurance. If not, you should start looking for an individual policy. Don't wait until that first ER trip gets you \$10,000 in debt.

#### If you're headed to the military...

The military often will send you to the infirmary when you're sick. They may also cover you when you're off base. Most individual policies will not cover someone while they are on military duty. If you are looking into a separate policy, remember to read the exclusions.

#### If you're headed to college...

Check your parents' policy. If you maintain a full-time student status, you could stay on their policy. If the college is offering a student health policy, read the policy very carefully. Some policies cover you adequately, but some may be lacking coverage important to you.



### Types of Coverage

**major medical policies:** generally have a deductible and a co-insurance with a lifetime maximum limit. (This is usually \$1M or more) These policies cover medically necessary doctor visits and hospitalizations along with physical

therapy, outpatient surgery, etc. This type of policy can be offered with or without a PPO network provision. This offer would be up to the insurance company.

**HMO policies:** Health Maintenance Organizations offer coverage similar to that of a major medical policy. These policies have co-payment obligations for you for the various covered benefits. This is a managed care plan where you choose your primary care physician (PCP) from a list of network providers. Your PCP is typically responsible for the management of most aspects relating to your healthcare. HMOs may require that an in-network doctor provide care in order to have your claim paid by the HMO. (There are exceptions for emergency room care) Be sure to read the policy related to emergency room care coverage. Many HMOs require referrals and pre-authorizations for any care other than a PCP visit. Be sure you understand your contract and your obligations for getting referrals and pre-certifications before you receive treatment. These policies will also have exclusions and non-covered services in the same way as a major medical policy. Make sure you understand the limitations on your policy.

**PPO policies:** Preferred Provider Organizations provide consumers with economic incentives if they contract to patronize a particular group of healthcare providers. There are many types and styles of PPOs. One common style of PPO may pay 80/20 if you go to a doctor that is in the network of providers. The PPO will pay for 80% of your bill; you pay 20% after any applicable deductibles. If you go out of the network, the amount a PPO pays will change (usually less).

**hospital/surgical policies:** offer a schedule of benefits for specific services. These policies list the medical service and the maximum the policy will pay for each service. For example the schedule will list various types of surgery with a limit. There may be limits on the payment toward surgeon fees, daily hospital room fees, etc, regardless of the actual cost of the service. These policies also have exclusions and exceptions, so read the contract carefully.

**indemnity policies:** offer a fixed amount of payment for the type of service or disease or injury. Hospital indemnity and specified disease (Cancer generally) policies pay limited amounts. The policy will chart out when coverage is applicable and what the specific amount is that they will pay.



## Policy Terms

**usual & customary charges:** the company has a standard rate for a procedure or visit. If the doctor charges above that amount, they exceed the company's "usual and customary amount".

**co-insurance:** the amount you pay to the doctor or provider after the plan pays. The doctor directly collects this amount of your shared cost of insurance. Co-pays are listed as percentages. For example a 70/30 plan means the company pays 70% and your shared cost is 30%.

**deductible:** the specific amount of claims you will pay before the company pays. *The higher your deductible, the lower your premium can be.*

**co-pay:** a certain amount that you pay for medical costs. For example, you pay \$5 every time you have a prescription filled.

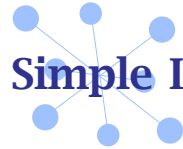
**pre-existing conditions:** a condition that occurs before you get health coverage. Companies can and do exclude coverage for pre-existing conditions. Once you get sick or are diagnosed with a health condition, it is usually too late to get coverage. If you do find coverage, the price will be higher or the options will be lower. **ADVICE: GET HEALTH COVERAGE WHILE YOU ARE HEALTHY!**

**waivers and exclusions:** some companies develop policies with certain exclusions in mind. A policy exclusion is a statement that the company will not pay for certain types of accidents or sicknesses. A waiver becomes part of the policy after you sign it. A waiver usually is put together for the company to exclude a specific illness you may have or a previous injury. Most waivers are permanent. Waivers may come off of a policy only when you and the company agree to take them off. If you sign a waiver, most of the time the only way to get coverage is to go buy a new policy.

**grievance:** HMO and PPO plans are required to provide a way for you to appeal coverage or benefit decisions you believe are wrong. If you

think your claim is incorrectly denied or you are being treated unfairly, state law requires plans to administer a process to resolve those disputes. This gives you a quick and inexpensive way to resolve a grievance, but you still have the right to sue the plan if necessary.

**pre-certification:** some plans require that you pre-certify a healthcare service or procedure. If the policy states that prior approval by the company is needed, you may be stuck with the bill if you do not get a pre-certification.



## Simple Lesson

1. Bob's PPO states that his co-insurance is 80/20. Bob's bill just came in at \$200.00. The PPO pays \$\_\_\_\_\_ and Bob pays the doctor \$\_\_\_\_\_?

2. Heather signed a waiver that says her pre-existing condition for bad hair coloring will not be covered. She signed up for an indemnity plan that pays for basic accidents and sicknesses. If Heather had a bad hair coloring accident would the insurance company be required to pay? How long does her waiver last?

3. You feel that your claim was mishandled or denied. What is the first and least expensive step to help you resolve your dispute?

- A. File a Grievance
- B. Call the Consumer Insurance Hotline
- C. Contact a Lawyer
- D. Pitch a fit in the lobby of the insurance company.

**Answers:**  
1. \$160 & \$40 2. Heather has signed a waiver, which does not come off until the company agrees or she gets other insurance 3. The Department recommends you start with "A", but is able to assist if needed. "D" is really not recommended.

**Missouri Department of Insurance,  
Financial Institutions & Professional Registration  
P.O. Box 690  
Jefferson City, MO 65102**

**Consumer Insurance Hotline  
1-800-726-7390**

**<http://www.insurance.mo.gov>**